DEPARTMENT OF HUMAN SERVICES
SENIORS AND PEOPLE WITH DISABILITIES
OREGON ADMINISTRATIVE RULES

CHAPTER 411
DIVISION 30

IN-HOME SERVICES

411-030-0001
(Renumbered to OAR 411-030-0040 6/1/1993)

411-030-0002 Purpose
(Amended 1/1/2009)

The rules in OAR chapter 411, division 030 ensure that in-home services maximize independence, empowerment, dignity, and human potential through provision of flexible, efficient, and suitable services to eligible individuals. In-home services fill the role of complementing and supplementing an individual's own personal abilities to continue to live in his or her own home.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070

411-030-0020 Definitions
(Amended 1/1/2009)

As used in these rules:

(1) "Activities of Daily Living (ADL)" means those personal, functional activities required by an individual for continued well-being, which are essential for health and safety. Activities consist of eating, dressing/grooming, bathing/personal hygiene, mobility (ambulation and transfer), elimination (toileting, bowel, and bladder management), and cognition/behavior as defined in OAR 411-015-0006.

(2) "Architectural Modifications" means any service leading to the alteration of the structure of a dwelling to meet a specific service need of the eligible individual.

(3) "Area Agency on Aging (AAA)" means the Department of Human Services designated agency charged with the responsibility to provide a comprehensive and coordinated system of services to seniors or people with disabilities in a planning and service area. For purposes of these rules, the term Area Agency on Aging is inclusive of both Type A and Type B Area Agencies on Aging as defined in ORS 410.040 and described in ORS 410.210 through 410.300.

(4) "Assistive Devices" means any category of durable medical equipment, mechanical apparatus, electrical appliance, or instrument of technology used to assist and enhance an individual's independence in performing any activity of daily living. Assistive devices include the use of service animals, general household items, or furniture to assist the individual.

(5) "Business Days" means Monday through Friday and excludes Saturdays, Sundays, and state or federal holidays.

(6) "Case Manager" means an employee of the Department of Human Services or Area Agency on Aging who assesses the service needs of an applicant, determines eligibility, and offers service choices to the eligible individual. The case manager authorizes and implements the service plan, and monitors the services delivered.

(7) "Client" or "Client-Employer" means the individual eligible for in-home services. “Individual” is synonymous with client.

(8) "Client Assessment and Planning System (CA/PS)” is a single entry data system used for completing a comprehensive and holistic assessment, surveying the individual's physical, mental, and social functioning, and identifying risk factors, individual choices, and preferences, and the status of service needs. The CA/PS documents the level of need and calculates the individual's service priority level in accordance with OAR chapter 411, division 015, calculates the service payment rates, and accommodates individual participation in service planning.

(9) "Client-Employed Provider Program (CEP)" refers to the program wherein the provider is directly employed by the client and provides either hourly or live-in services. In some aspects of the employer and employee relationship, the Department of Human Services acts as an agent for the

client-employer. These functions are clearly described in OAR 411-031-0040.

(10) "Contingency Fund" means a monetary amount set aside in the Independent Choices Program service budget that continues month to month if approved by the case manager, to purchase identified items that substitute for personal assistance.

(11) "Contracted In-Home Care Agency" means an incorporated entity or equivalent, licensed in accordance with OAR chapter 333, division 536 that provides hourly contracted in-home services to individuals served by the Department of Human Services or Area Agency on Aging.

(12) "Cost Effective" means being responsible and accountable with Department of Human Services resources. This is accomplished by offering less costly alternatives when providing choices that adequately meet an individual's service needs. Those choices include other programs available from the Department of Human Services, the utilization of assistive devices, natural supports, architectural modifications, and alternative service resources (defined in OAR 411-015-0005). Less costly alternatives may include resources not paid for by the Department of Human Services.

(13) "DHS" means the Department of Human Services.

(14) "Discretionary Fund" means a monetary amount set aside in the Independent Choices Program service budget to purchase items not otherwise delineated in the monthly service budget or agreed to be savings for items not traditionally covered under waivered services. Discretionary funds must be expended at the end of each month.

(15) "Disenrollment" means either voluntary or involuntary termination of the participant from the Independent Choices Program.

(16) "DMAP" means the Division of Medical Assistance Programs.

(17) "Employee Provider" means a worker who provides services to, and is a paid provider for, a participant in the Independent Choices Program.

(18) "Employment Relationship" means the relationship involving the employee provider and the participant as employee and employer.

(19) "Exception" means an approval for payment of a service plan granted to a specific individual in their current residence (or in the proposed residence identified in the exception request) that exceeds the CA/PS assessed service payment levels for individuals residing in community-based care facilities or the maximum hours of service as described in OAR 411-030-0070 for individuals residing in their own homes. The approval is based on the service needs of the individual and is contingent upon the service plan meeting the requirements in OAR 411-027-0020, OAR 411-027-0025, and OAR 411-027-0050. The term "exception" is synonymous with "exceptional rate" or "exceptional payment."

(20) "FICA" is the acronym for the Social Security payroll taxes collected under authority of the Federal Insurance Contributions Act.

(21) "Financial Accountability" refers to guidance and oversight which act as fiscal safeguards to identify budget problems on a timely basis and allow corrective action to be taken to protect health and welfare of individuals.

(22) "FUTA" is the acronym for Federal Unemployment Tax Assessment which is a United States payroll (or employment) tax imposed by the federal government on both employees and employers.

(23) "Homecare Worker (HCW)" means a provider, as described in OAR 411-031-0040, that provides either hourly or live-in services to eligible individuals and is employed by the individual. The term homecare worker includes client-employed providers in the Spousal Pay and Oregon Project Independence Programs. It also includes client-employed providers that provide state plan personal care services to seniors and people with physical disabilities. Homecare worker does not include Independent Choices Program providers or personal care attendants enrolled through Developmental Disability Services or the Addictions and Mental Health Division.

(24) "Hourly Services" means the in-home services, including activities of daily living and self-management tasks, that are provided at regularly scheduled times.

(25) "Independent Choices Program (ICP)" means a self directed In-Home Services Program in which the participant is given a cash benefit to

purchase goods and services identified in a service plan and prior approved by the Seniors and People with Disabilities Division or Area Agency on Aging case manager.

(26) "Individualized Back-Up Plan" means a plan incorporated into the Independent Choices Program service plan to address critical contingencies or incidents that pose a risk or harm to the participant's health and welfare.

(27) "In-Home Services" means those activities of daily living and self-management tasks that assist an individual to stay in his or her own home.

(28) “Liability” refers to the dollar amount individuals with excess income must contribute to the cost of service pursuant to OAR 461-160-0610 and OAR 461-160-0620.

(29) "Live-In Services" means those Client-Employed Provider Program services provided when an individual requires activities of daily living, self-management tasks, and twenty-four hour availability. Time spent by any live-in employee doing self-management and twenty-four hour availability are exempt from federal and state minimum wage and overtime requirements. To ensure continuity of service for the individual, live-in service plans must include at least one homecare worker providing twenty-four hour availability for a minimum of five days in a calendar week.

(30) "Natural Supports" or "Natural Support System" means the resources available to an individual from their relatives, friends, significant others, neighbors, roommates, and the community. Services provided by natural supports are resources that are not paid for by the Department of Human Services.

(31) "Oregon Project Independence (OPI)" means the program of in-home services described in OAR chapter 411, division 032.

(32) "Participant" means an individual eligible for Independent Choices Program services.

(33) "Provider" means the individual who actually renders the service.

(34) "Rate Schedule" means the rate schedule published by the Seniors and People with Disabilities Division at http://www.oregon.gov/DHS/spd/provtools/rateschedule.pdf.

(35) "Representative" is a person either appointed by the individual to participate in service planning on the individual's behalf or the individual's natural support with longstanding involvement in assuring the individual's health, safety, and welfare. There are additional responsibilities for the Independent Choices Program representatives as described in OAR 411-030-0100. An ICP representative may not be a paid employee provider regardless of relationship to the participant.

(36) "Self-Management" or "Instrumental Activities of Daily Living (IADL)" means those activities, other than activities of daily living, required by an individual to continue independent living. The definitions and parameters for assessing needs in self-management tasks are identified in OAR 411-015-0007.

(37) "Service Budget" means the participant's plan for the distribution of authorized funds that are under the control and direction of the participant within the Independent Choices Program. The service budget is a required component of the service plan.

(38) "Service Need" means the assistance an individual requires from another person for those functions or activities identified in OAR 411-015-0006 and OAR 411-015-0007.

(39) "SPD" means the Department of Human Services, Seniors and People with Disabilities Division.

(40) "SUTA" is the acronym for State Unemployment Tax Assessment. State unemployment taxes are paid by employers to finance the unemployment benefit system that exists in each state.

(41) "These Rules" means the rules in OAR chapter 411, division 030.

(42) "Twenty-Four Hour Availability" means the availability and responsibility of an employee to meet activities of daily living and self-management needs of an eligible individual as required by that person over a 24 hour period. Twenty-four hour availability services are provided by a

live-in employee and are exempt from federal and state minimum wage and overtime requirements.

(43) "Waivered Services" means services provided through Oregon's Medicaid Home and Community-Based Services Waiver under the authority of section 1915 (c) of the Social Security Act, that allows the state to provide home and community-based services to eligible individuals in place of nursing facility services. Waivered services include in-home services, residential care facility services, assisted living facility services, adult foster care services, home-delivered meals (when provided in conjunction with in-home services), specialized living services, Spousal Pay Program services, and adult day services.

Stat. Auth.: ORS 409.050, 410.070 & 410.090
Stats. Implemented: ORS 410.010, 410.020 & 410.070

411-030-0022
(Renumbered to OAR 411-030-0050 6/1/1993)

411-030-0027
(Renumbered to OAR 411-030-0080 6/1/1993)

411-030-0033 Program Scope
(Amended 1/1/2009)

(1) In-home services are designed to provide essential supportive services that enable an individual to remain in his or her own home. In-home services range from assistance with household tasks to assistance with ADL. The extent of the services may vary from a few hours per week to full-time. Live-in services may be an option depending on the program.

(2) In-home services may be provided through the Home and Community-Based Services Waivered In-Home Services Program, Independent Choices Program, Spousal Pay Program, or Oregon Project Independence Program.

(3) PERMISSIBLE IN-HOME SERVICES LIVING ARRANGEMENTS.

(a) The following terms are used in this rule:

(A) "Informal arrangement" means a paid or unpaid arrangement for shelter or utility costs that does not include the elements of a property manager's rental agreement.

(B) "Property manager's rental agreement" means a payment arrangement for shelter or utility costs with a property owner, property manager, or landlord that includes all of the following elements:

(i) The name and contact information for the property manager, landlord, or leaser;

(ii) The period or term of the agreement and method for terminating the agreement;

(iii) The number of tenants or occupants;

(iv) The rental fee and any other charges (such as security deposits);

(v) The frequency of payments (such as monthly);

(vi) What costs are covered by the amount of rent charged (such as shelter, utilities, or other expenses); and

(vii) The duties and responsibilities of the property manager and the tenant, such as:

(I) The person responsible for maintenance;

(II) If the property is furnished or unfurnished; and

(III) Advance notice requirements prior to an increase rent

(C) "Provider-owned dwelling" means a dwelling that is owned by the provider or the provider's spouse when the provider is proposing to be paid through waivered services. The dwelling does not include the name of the individual on the property

deed, mortgage, or title. Provider-owned dwellings include, but are not limited to:

(i) Houses, apartments, and condominiums;

(ii) A portion of a house such as basement or a garage even when remodeled to be used as a separate dwelling;

(iii) Trailers and mobile homes; or

(iv) Duplexes, unless the structure displays a separate address from the other residential unit and was originally built as a duplex.

(D) "Provider-rented dwelling" means a dwelling that is rented or leased by the provider or the provider's spouse when the provider is proposing to be paid through waivered services. The dwelling does not include the name of the individual on the property manager's rental agreement.

(b) An individual residing in any of the following living arrangements shall not be eligible for the Home and Community-Based Services Waivered In-Home Services Program:

(A) The individual resides in a provider-owned dwelling. Such a setting may meet the requirements for a relative adult foster home or a limited adult foster home as described in OAR 411-050-0405; or

(B) The individual resides in a provider-rented dwelling through an informal arrangement.

(c) If the individual's name is added to the property deed, mortgage, title, or property manager's rental agreement, the individual may be considered for waivered in-home services.

Stat. Auth.: ORS 409.050, 410.070 & 410.090
Stats. Implemented: ORS 410.010, 410.020 & 410.070

411-030-0040 Eligibility Criteria

(Amended 1/1/2009)

(1) In-home services may be provided to those individuals who meet the established priorities for service as described in OAR chapter 411, division 015 and have been assessed to be in need of a service provided in these rules. Payments for in-home services are not intended to replace the resources available to an individual from their natural supports. Payment by SPD shall be considered or authorized only when natural supports are not available, not sufficient, or not developed to adequately meet the needs of an individual. An individual whose service needs are sufficiently and appropriately met by available natural supports shall not be eligible for in-home services. Service plans must be based upon the least costly means of providing adequate care.

(2) Individuals served under the Home and Community-Based Services Waivered In-Home Services Program or the Independent Choices Program must meet the established priorities for service as described in OAR chapter 411, division 015 and must:

(a) Be current recipients of OSIPM (Oregon Supplemental Income Program Medical);

(b) Reside in a living arrangement in which in-home services may be provided as described in OAR 411-030-0033; and

(c) Be eighteen years of age or older.

(3) To be eligible for the Home and Community-Based Services Waivered In-Home Services Program, an individual must employ an enrolled homecare worker or contracted in-home care agency to provide the services prior authorized and paid for by SPD. To be eligible for the Independent Choices Program, participants must employ an employee provider or contracted in-home care agency.

(a) Initial eligibility for waivered in-home services or the Independent Choices Program may not begin until a service plan has been authorized. The service plan must identify the provider who delivers the authorized services, and must include the date when the provision of services begins and the maximum number of hours authorized.

(b) If, for any reason, the employment relationship between the individual and provider is discontinued, an enrolled homecare worker or contracted in-home care agency must be employed within 14 business days for the individual to remain eligible for in-home services. Participants of the Independent Choices Program must employ an employee provider within 14 business days.

(c) An eligible individual who has been receiving waivered in-home services and temporarily enters a nursing facility or medical institution must employ an enrolled homecare worker or contracted in-home care agency within 14 business days of discharge from the facility or institution. Participants of the Independent Choices Program must employ an employee provider within 14 business days of discharge.

(4) EMPLOYER RESPONSIBILITIES.

(a) In order to be eligible for in-home services provided by a homecare worker, an individual must be able to, or designate a representative to:

(A) Locate, screen, and hire a qualified homecare worker;

(B) Supervise and train the homecare worker;

(C) Schedule work, leave, and coverage;

(D) Track the hours worked and verify the authorized hours completed by the homecare worker;

(E) Recognize, discuss, and attempt to correct, with the homecare worker, any performance deficiencies; and

(F) Discharge unsatisfactory workers.

(b) Individuals who have demonstrated, after intervention and assistance, that they are unable to meet the responsibilities in section (4)(a) of this rule shall be determined ineligible for in-home services provided by a homecare worker. Individuals ineligible for in-home services provided by a homecare worker shall be offered other

available, community-based service options that meet the individual's service needs, including contracted in-home care agency services when possible. As an alternative to community-based waivered services, DHS may offer nursing facility services, if available, to meet an individual's service needs.

(c) Individuals determined ineligible for in-home services provided by a homecare worker may request in-home services provided by a homecare worker at the individual's next annual re-assessment. To be eligible for in-home services provided by a homecare worker, individuals must appoint a representative or attend training, and acquire or otherwise demonstrate the ability to meet the employment responsibilities in section (4)(a) of this rule. Improvements in health and cognitive functioning may be factors in demonstrating the ability to meet employment responsibilities. If an individual is able to demonstrate the ability to meet employment responsibilities sooner than the next annual re-assessment, the waiting period may be shortened.

(d) An individual must designate a different representative or select other available services if the individual's designated representative is unable to meet the employer responsibilities in section (4)(a) of this rule.

(5) REPRESENTATIVE.

(a) SPD may deny an individual’s request for any representative if the representative has a history of a substantiated adult protective service complaint as described in OAR chapter 411, division 020. The individual shall be given the option to select another representative.

(b) Individuals with guardians must have a representative for service planning purposes. Guardians may designate themselves the representative.

(6) Additional eligibility criteria for in-home services exist for persons eligible for:

(a) Oregon Project Independence as described in OAR chapter 411, division 032;

(b) Independent Choices Program as described in OAR 411-030-0100; or

(c) Spousal Pay Program as described in OAR 411-030-0080.

(7) Residents of licensed community-based care facilities, nursing facilities, prisons, hospitals, and other institutions that provide assistance with ADL are not eligible for in-home services.

(8) Individuals with excess income must contribute to the cost of service pursuant to OAR 461-160-0610 and OAR 461-160-0620.

Stat. Auth.: ORS 409.050, 410.070 & 410.090
Stats. Implemented: ORS 410.010, 410.020 & 410.070

411-030-0050 Case Management
(Amended 1/1/2009)

(1) ASSESSMENT.

(a) The assessment process must identify the individual's ability to perform ADL, self-management tasks, and determine the individual's ability to address health and safety concerns. The case manager must conduct this assessment in accordance with standards of practices established by SPD in OAR 411-015-0008.

(b) The assessment must be conducted by a case manager or other qualified SPD/AAA representative in the home of the eligible individual, no less than annually, with a standardized assessment tool approved by SPD.

(2) CONTRACT REGISTERED NURSE (RN) SERVICES.

(a) Contract RN services must be prior authorized by a SPD/AAA case manager and provided according to OAR chapter 411, division 048.

(b) Indicators of the need for contract RN services may include:

(A) Full assistance in cognition;

(B) Medical instability;

(C) Potential for skin breakdown or decubitus ulcer;

(D) Multiple health problems or frailty with a strong probability of deterioration; or

(E) Potential for increased self-care, but instruction and support for the individual are needed to reach goals.

(c) Maximum hours for each contracted RN service shall be established by SPD.

(3) SERVICE PLAN.

(a) The individual and case manager, with the assistance of others involved, must consider in-home service options as well as assistive devices, architectural modifications, and other community-based care resources to meet the service needs identified in the assessment process.

(b) The individual, or their representative, has the responsibility to choose and assist in developing less costly service alternatives, including the Client-Employed Provider Program and contracted in-home care agency services.

(c) The case manager has responsibility for determining eligibility for specific services, presenting alternatives to the individual, identifying risks, and assessing the cost effectiveness of the service plan. The case manager must monitor the service plan and make adjustments as needed.

(A) In implementing the service plan in accordance with 42 CFR 441.302, SPD must take necessary safeguards to protect the health, safety, and welfare of the individual.

(B) When an individual with the ability to make an informed decision selects a service choice that jeopardizes health and

safety, SPD/AAA staff shall offer options to the individual in order to minimize those risks. For the purpose of this rule, an "informed decision" means the individual understands the benefits, risks, and consequences of the service choice selected.

(C) Options that minimize risks may include offering or recommending:

(i) Natural supports to provide assistance with safety or health emergencies;

(ii) An emergency response system;

(iii) A back-up plan for assistance with service needs;

(iv) Resources for emergency disaster planning;

(v) A referral for contract RN services;

(vi) Resources for provider training;

(vii) Assistive devices; or

(viii) Architectural modifications.

(d) SPD/AAA may not authorize a service provider, service setting, or a combination of services selected by the eligible individual or the representative when:

(A) The service setting has dangerous conditions that jeopardize the health or safety of the individual and necessary safeguards cannot be taken to improve the setting;

(B) Based on the extent of the service needs, or the choices or preferences of the eligible individual or the representative, services cannot be provided safely or adequately by the service provider;

(C) Dangerous conditions in the service setting jeopardize the health or safety of the service provider that is authorized and

paid by SPD, and necessary safeguards cannot be taken to minimize the dangers; or

(D) The individual does not have the ability to make an informed decision, does not have a designated representative to make decisions on his or her behalf, and SPD/AAA cannot take necessary safeguards to protect the safety, health, and welfare of the individual.

(e) The case manager must present the individual or representative information on service alternatives and provide assistance to assess other choices when the service provider or service setting selected by the individual or representative is not authorized.

(f) The service plan payment must be considered full payment for the services rendered under Title XIX. Under no circumstances is the employee to demand or receive additional payment for these Title XIX-covered services from the client-employer or any other source. Additional payment to homecare workers or Independent Choices Program employee providers for the same services covered by Oregon's Title XIX Home and Community-Based Services Waiver or Spousal Pay Programs is prohibited.

(g) For the Independent Choices Program, the service plan must include the service budget as per OAR 411-030-0100.

(h) SPD may not authorize a hardship shelter allowance associated with employing a live-in provider on or after June 1, 2006.

(i) Individuals eligible for and authorized to receive a hardship shelter allowance before June 1, 2006 may continue to receive a hardship shelter allowance on or after June 1, 2006 at the rate established by SPD if one of the following conditions is met:

(A) The individual shall be forced to move from their current dwelling and the individual's current average monthly rent or mortgage costs exceed current OSIP and OSIPM standards for a one-person need group as outlined in OAR 461-155-0250; or

(B) Service costs significantly increase as a result of the individual being unable to provide living quarters for a necessary live-in provider.

Stat. Auth.: ORS 409.050, 410.070 & 410.090
Stats. Implemented: ORS 410.010, 410.020 & 410.070

411-030-0055 Service Plan-Related Transportation
(Amended 1/1/2009)

(1) Service-related transportation (non-medical) may be prior-authorized for reasons related to an eligible individual's safety or health, in accordance with a service plan. Such services shall be offered through contracted transportation providers or by homecare workers.

(2) Service-related transportation may be authorized to assist an eligible individual in getting to and from the individual's place of employment when that individual is approved for the Employed Persons with Disabilities Program (OSIPM-EPD).

(3) Natural supports, volunteer transportation, and other transportation services available to the eligible individual shall be considered a prior resource and must not be replaced with transportation paid by DHS.

(a) DMAP is a prior resource for medical transportation to a physician, hospital, clinic, or other medical service provider. Medical transportation costs may not be reimbursed through service-related transportation.

(b) DHS may not provide service-related transportation to obtain medical or non-medical items that may be delivered by a supplier or sent by mail order without cost to the eligible individual.

(4) Transportation must be prior authorized by the case manager and documented in the service plan. Under no circumstances shall any provider receive payment from DHS for more than the total number of hours, miles, or rides authorized by SPD/AAA in the service plan.

(a) Contracted transportation providers must be reimbursed according to the terms of their contract with DHS. Service

transportation services provided through contracted transportation providers must be authorized by the case manager based on an estimate of a total count of one way rides per month.

(b) Homecare workers must be reimbursed according to the terms defined in their collective bargaining agreement when they use their own personal vehicle for service-related transportation. Any mileage reimbursement authorized to a homecare worker must be based on an estimate of the monthly maximum miles required to drive to and from the destination authorized in the service plan. Transportation hours are authorized in accordance with OAR 411-030-0070.

(c) SPD/AAA shall not authorize reimbursement for travel to or from the residence of the homecare worker. Transportation and mileage may only be authorized from the home of the eligible individual to the destination authorized in the service plan and back to the eligible individual's home.

(5) DHS is not responsible for any vehicle damage or personal injury sustained while using a personal motor vehicle for service-related transportation.

Stat. Auth.: ORS 409.050, 410.070 & 410.090
Stats. Implemented: ORS 410.010, 410.020 & 410.070

411-030-0060 Client Employed Provider Program
(Repealed 6/7/2004 – Moved to OAR chapter 411, division 031)

411-030-0065 Administrative Review and Hearing Rights
(Repealed 6/7/2004 – Moved to OAR chapter 411, division 031)

411-030-0070 Maximum Hours of Service
(Amended 6/1/2012)

(1) LEVELS OF ASSISTANCE FOR DETERMINING SERVICE PLAN HOURS.

(a) "Minimal Assistance" means the individual is able to perform the majority of an activity, but requires some assistance from another person.

(b) "Substantial Assistance" means the individual can perform only a small portion of the tasks that comprise the activity without assistance from another person.

(c) "Full Assistance" means the individual needs assistance from another person through all phases of the activity, every time the activity is attempted.

(2) MAXIMUM MONTHLY HOURS FOR ADL.

(a) The planning process uses the following limitations for time allotments for ADL tasks. Hours authorized must be based on the service needs of the individual. Case managers may authorize up to the amount of hours identified in these assistance levels (minimal, substantial, or full assist).

(A) Eating:

(i) Minimal assistance, 5 hours;

(ii) Substantial assistance, 20 hours;

(iii) Full assistance, 30 hours;

(B) Dressing/Grooming:

(i) Minimal assistance, 5 hours;

(ii) Substantial assistance, 15 hours;

(iii) Full assistance, 20 hours;

(C) Bathing and Personal Hygiene:

(i) Minimal assistance, 10 hours;

(ii) Substantial assistance, 15 hours;

(iii) Full assistance, 25 hours;

(D) Mobility:

(i) Minimal assistance, 10 hours;

(ii) Substantial assistance, 15 hours;

(iii) Full assistance, 25 hours;

(E) Elimination (Toileting, Bowel, and Bladder):

(i) Minimal assistance, 10 hours;

(ii) Substantial assistance, 20 hours;

(iii) Full assistance, 25 hours;

(F) Cognition/Behavior:

(i) Minimal assistance, 5 hours;

(ii) Substantial assistance, 10 hours;

(iii) Full assistance, 20 hours.

(b) Service plan hours for ADL may only be authorized for an individual if the individual requires assistance (minimal, substantial, or full assist) from another person in that activity of daily living as determined by a service assessment applying the parameters in OAR 411-015-0006.

(c) For households with two or more eligible individuals, each individual's ADL service needs must be considered separately. In accordance with section (3)(c) of this rule, authorization of IADL hours shall be limited for each additional individual in the home.

(d) Hours authorized for ADL are paid at hourly rates in accordance with the rate schedule. The Independent Choices Program cash benefit is based on the hours authorized for ADLs paid at the hourly

rates. Participants of the Independent Choices Program may determine their own employee provider pay rates.

(3) MAXIMUM MONTHLY HOURS FOR IADL.

(a) The planning process uses the following limitations for time allotments for IADL tasks. Hours authorized must be based on the service needs of the individual. Case managers may authorize up to the amount of hours identified in these assistance levels (minimal, substantial, or full assist).

(A) Medication and Oxygen Management:

(i) Minimal assistance, 2 hours;

(ii) Substantial assistance, 4 hours;

(iii) Full assistance, 6 hours;

(B) Transportation or Escort Assistance:

(i) Minimal assistance, 2 hours;

(ii) Substantial assistance, 3 hours;

(iii) Full assistance, 5 hours;

(C) Meal Preparation:

(i) Minimal assistance prior to January 1, 2012:

(I) Breakfast, 4 hours;

(II) Lunch, 4 hours;

(III) Supper, 8 hours.

(ii) Minimal assistance effective January 1, 2012:

(I) Breakfast, 3 hours;

(II) Lunch, 3 hours;

(III) Supper, 7 hours.

(iii) Substantial assistance prior to January 1, 2012:

(I) Breakfast, 8 hours;

(II) Lunch, 8 hours;

(III) Supper, 16 hours.

(iv) Substantial assistance effective January 1, 2012:

(I) Breakfast, 7 hours;

(II) Lunch, 7 hours;

(III) Supper, 14 hours.

(v) Full assistance prior to January 1, 2012:

(I) Breakfast, 12 hours;

(II) Lunch, 12 hours;

(III) Supper, 24 hours.

(vi) Full assistance effective January 1, 2012:

(I) Breakfast, 10 hours;

(II) Lunch, 10 hours;

(III) Supper, 21 hours.

(D) Shopping:

(i) Minimal assistance, 2 hours;

(ii) Substantial assistance, 4 hours;

(iii) Full assistance, 6 hours;

(E) Housecleaning:

(i) Minimal assistance:

(I) Prior to January 1, 2012, 5 hours.

(II) Effective January 1, 2012, 4 hours.

(ii) Substantial assistance:

(I) Prior to January 1, 2012, 10 hours.

(II) Effective January 1, 2012, 9 hours.

(iii) Full assistance:

(I) Prior to January 1, 2012, 20 hours.

(II) Effective January 1, 2012, 18 hours.

(b) Rates shall be paid in accordance with the rate schedule. When a live-in employee is present, these hours may be paid at less than minimum wage according to the Fair Labor Standards Act. The Independent Choices Program cash benefit is based on the hours authorized for IADL tasks paid at the hourly rates. Participants of the Independent Choices Program may determine their own employee provider pay rates.

(c) When two or more individuals eligible for IADL task hours live in the same household, the assessed IADL need of each individual must be calculated. Payment shall be made for the highest of the allotments and a total of four additional IADL hours per month for each additional individual to allow for the specific IADL needs of the other individuals.

(d) Service plan hours for IADL tasks may only be authorized for an individual if the individual requires assistance (minimal, substantial, or full assist) from another person in that IADL task as determined by a service assessment applying the parameters in OAR 411-015-0007.

(4) TWENTY-FOUR HOUR AVAILABILITY.

(a) Payment for 24-hour availability shall be authorized only when an individual employs a live-in homecare worker or Independent Choices Program employee provider and requires 24-hour availability due to the following:

(A) The individual requires assistance with ADL or IADL tasks at unpredictable times throughout most 24-hour periods; and

(B) The individual requires minimal, substantial, or full assistance with ambulation and requires assistance with transfer (as defined in OAR 411-015-0006); or

(C) The individual requires full assistance in transfer or elimination (as defined in OAR 411-015-0006); or

(D) The individual requires full assist in at least three of the eight components of cognition/behavior (as defined in OAR 411-015-0006).

(b) The number of hours allowed per month shall have the following maximums. Hours authorized are based on the service needs of the individual. Case managers may authorize up to the amount of hours identified in these assistance levels (minimal, substantial, or full assist).

(A) Minimal assistance -- 60 hours. Minimal assistance hours may be authorized when an individual requires one of these assessed needs as defined in OAR 411-015-0006:

(i) Full assist in cognition; or

(ii) Full assist in toileting or bowel or bladder.

(B) Substantial assistance -- 110 hours. Substantial assistance hours may be authorized when an individual requires these assessed needs as defined in OAR 411-015-0006:

(i) Assist in transfer; and

(ii) Assist in ambulation; and

(iii) Full assist in cognition; or

(iv) Full assist in toileting or bowel or bladder.

(C) Full assistance -- 159 hours. Full assistance hours may be authorized when:

(i) The authorized provider cannot get at least five continuous hours of sleep in an eight hour period during a 24-hour work period; and

(ii) The eligible individual requires these assessed needs as defined in OAR 411-015-0006:

(I) Full assist in transfer; and

(II) Assist in mobility; or

(III) Full assist in toileting or bowel or bladder; or

(IV) Full assist in cognition.

(c) Service plans that include full-time live-in homecare workers or Independent Choices Program employee providers must include a minimum of 60 hours per month of 24-hour availability. When a live-in homecare worker or Independent Choices Program employee provider is employed less than full time, the hours must be pro-rated. Full-time means the live-in homecare worker is providing services to the client-employer seven days per week throughout a calendar month.

(d) Rates for 24-hour availability shall be in accordance with the rate schedule and paid at less than minimum wage according to the Fair Labor Standards Act and ORS 653.020.

(e) Twenty-four hour availability assumes the homecare worker is available to address the service needs of an individual as they arise throughout a 24-hour period. A homecare worker who engages in employment outside the eligible individual's home or building during the work periods the homecare worker is on duty, is not considered available to meet the service needs of the individual.

(5) Under no circumstances shall any provider receive payment from the Department for more than the total amount authorized by the Department on the service plan authorization form. All service payments must be prior-authorized by the Department/AAA.

(6) AUTHORIZED HOURS ARE SUBJECT TO THE AVAILABILITY OF FUNDS. Case managers must assess and utilize as appropriate, natural supports, cost-effective assistive devices, durable medical equipment, housing accommodations, and alternative service resources (as defined in OAR 411-015-0005) which could reduce the individual's reliance on paid in-home services hours.

(7) The Department may authorize paid in-home services only to the extent necessary to supplement potential or existing resources within the individual's natural supports system.

(8) Payment by the Department for waivered in-home services shall only be made for those tasks described in this rule as ADL, IADL tasks, and 24-hour availability. Services must be authorized to meet the needs of the eligible individual and may not be provided to benefit the entire household.

(9) EXCEPTIONS TO MAXIMUM HOURS OF SERVICE.

(a) To meet an extraordinary ADL service need that has been documented, the hours authorized for ADL may exceed the full assistance hours (described in section (2) of this rule) as long as the total number of ADL hours in the service plan does not exceed 145 hours per month.

(b) Monthly service payments that exceed 145 ADL hours per month may be approved by the Department when the exceptional payment criteria identified in OAR 411-027-0020 and OAR 411-027-0050 is met.

(c) Monthly service plans that exceed 145 ADL, 76 IADL, and 159 24-hour availability hours per month for a live-in homecare worker or Independent Choices Program employee provider, or that exceed the equivalent monthly service payment for an hourly services plan, may be approved by the Department when the exceptional payment criteria identified in OAR 411-027-0020 and OAR 411-027-0050 is met.

(d) As long as the total number of IADL task hours in the service plan does not exceed 76 hours per month and the service need is documented, the hours authorized for IADL tasks may exceed the hours for full assistance (as described in section (3) of this rule) for the following tasks and circumstances:

(A) Housekeeping based on medical need (such as immune deficiency);

(B) Short-term extraordinary housekeeping services necessary to reverse unsanitary conditions that jeopardize the health of the individual; or

(C) Extraordinary IADL needs in medication management or service-related transportation.

(e) Monthly service plans that exceed 76 hours per month in IADL tasks may be approved by the Department when the individual meets the exceptional payment criteria identified in OAR 411-027-0020 and OAR 411-027-0050.

Stat. Auth.: ORS 409.050, 410.070, & 410.090
Stats. Implemented: ORS 410.010, 410.020, & 410.070

411-030-0080 Spousal Pay Program
(Temporary Effective 9/26/2012 – 3/25/2013)

(1) The Spousal Pay Program is one of the live-in service options under in-home services for those who qualify.

(2) For the purposes of the Spousal Pay Program, a spouse is defined as a person who is legally married per OAR 461-001-0000 to an individual eligible for the In-Home Support Services Program.

(3) ELIGIBILITY. An individual may be eligible for the Spousal Pay Program when all of the following conditions are met:

(a) The individual has met all program requirements of the In-Home Support Services Program;

(b) The individual requires full assistance in at least four of the six ADLs described in OAR 411-015-0006 as determined by the assessment described in OAR chapter 411, division 015;

(c) The individual would otherwise require nursing facility services without home and community-based waivered in-home services;

(d) The individual has a medically-diagnosed, progressive, debilitating condition that limits additional ADL, or has experienced a spinal cord injury or similar disability with permanent impairment of the ability to perform ADLs;

(e) At the time of requesting enrollment in the Spousal Pay Program, the individual is determined, through a pre-admission screening (PAS) assessment (as defined in OAR 411-070-0005) to meet the requirements described in sections (3)(b), (3)(c) and (3)(d) of this rule. The PAS assessment is a second, independent assessment, conducted by a Department/AAA representative using the CA/PS;

(f) The individual’s service needs exceed in both extent and duration the usual and customary services rendered by one spouse to another;

(g) The spouse demonstrates the capability and health to provide the services and actually provides the principal services, including the majority of service plan hours, for which payment has been authorized;

(h) The spouse meets all requirements for enrollment as a homecare worker in the Client-Employed Provider Program as described in OAR 411-031-0040; and

(i) The Department has reviewed the request and approved program eligibility at enrollment and annually upon re-assessment.

(4) PAYMENTS.

(a) All payments must be prior authorized by the Department or the Department's designee.

(b) The hours authorized in the service plan must consist of one-half of the assessed hours for 24 hour availability, one-half of the assessed hours for self-management tasks, plus all of the hours for specific ADLs based on the service needs of the individual.

(c) Spousal pay providers are paid at live-in homecare worker rates for ADL, self-management tasks, and 24 hour availability, except as described otherwise in section (4)(d) of this rule as bargained in the Collective Bargaining Agreement between the Home Care Commission and Service Employees International Union, Local 503, OPEU as defined in OAR 411-031-0020.

(d) Homecare workers who marry their consumer-employer retain the same standard of compensation, if their employer meets the spousal pay eligibility criteria as described in section (3) of this rule. Additional self-management task hours may be authorized in the service plan when necessary to prevent a loss of compensation to the homecare worker following marriage to the consumer-employer.

(e) Spousal pay providers may not claim payment from the Department for hours that the spousal pay provider did not work unless paid leave is utilized.

(5) Spousal pay providers are subject to the provisions in OAR chapter 411, division 31 governing homecare workers enrolled in the Client-Employed Provider Program.

(6) Individuals receiving Spousal Pay Program services who have excess income must contribute to the cost of services pursuant to OAR 461-160-0610 and OAR 461-160-0620.

Stat. Auth.: ORS 409.050, 410.070, & 410.090
Stats. Implemented: ORS 410.010, 410.020, 410.070, 411.802, & 411.803

411-030-0090 Contracted In-Home Care Agency Services
(Amended 1/1/2009)

(1) Contracted in-home care agency services are one of the in-home service options for individuals eligible for Oregon's Home and Community-Based Services Waiver.

(2) In-home care agencies must be licensed in accordance with OAR chapter 333, division 536. The geographic service area in which the agency provides services must comply with OAR 333-536-0050. The specific services provided must be described in each contract's statement of work.

Stat. Auth.: ORS 409.050, 410.070 & 410.090
Stats. Implemented: ORS 410.010, 410.020 & 410.070

411-030-0100 Independent Choices Program
(Amended 1/1/2009)

(1) The Independent Choices Program (ICP) is an In-Home Services Program that empowers participants to self-direct their own service plans and purchase goods and services that enhance independence, dignity, choice, and well-being.

(2) The ICP is limited to a maximum of 2,600 participants.

(a) SPD shall establish and maintain a waiting list for individuals eligible for in-home services requesting ICP after the ICP has reached its maximum.

(b) SPD shall enter names on the waiting list according to the date submitted by the SPD/AAA office.

(c) As vacancies occur, eligible individuals on the waiting list shall be offered the ICP in order according to their place on the waiting list.

(d) Individuals on the waiting list may receive services through other appropriate DHS programs for which they are eligible.

(3) INITIAL ELIGIBILITY REQUIREMENTS.

(a) To be eligible for the ICP an individual must:

(A) Meet all program requirements of the In-Home Services Program in these rules;

(B) Develop a service plan and budget to meet the needs identified in the CA/PS assessment;

(C) Sign the ICP participation agreement;

(D) Have or be able to establish a checking account;

(E) Provide evidence of a stable living situation for the past three months; and

(F) Demonstrate the ability to manage money as evidenced by timely and current utility and housing payments.

(b) If the participant is unable to direct and purchase his or her own in-home services, the participant must have a representative to act on the participant's behalf. The "representative" is the person assigned by the participant to act as the participant's decision maker in matters pertaining to the ICP service plan and service budget. A representative must:

(A) Complete a criminal history check pursuant to OAR chapter 407, division 007 and receive a final fitness determination of approval; and

(B) Sign and adhere to the "Independent Choices Program Representative Agreement" on behalf of the participant.

(c) If the participant is unable to manage ICP cash payment accounting, tax, or payroll responsibilities and does not have a representative, the participant must arrange and purchase the ongoing services of a fiscal intermediary, such as an accountant, bookkeeper, or equivalent financial services. Participants, or their representative, who have met the eligibility criteria in section (3)(b) of this rule, may also choose to use a fiscal intermediary. The participant is responsible for any fees or payment to the fiscal intermediary and may allocate the fees or payment from their discretionary funds or other non ICP funds.

(4) DISENROLLMENT CRITERIA. Participants may be disenrolled from the ICP voluntarily or involuntarily. Participants who are disenrolled from the ICP may not reapply for six months. After the six month disenrollment period, an individual may re-enroll and must meet all ICP eligibility requirements. If the ICP enrollment cap has been reached, participants who were disenrolled shall be added to the waiting list.

(a) Voluntary disenrollment. Participants or representatives must provide notice to SPD of intent to discontinue participation. The participant or the representative must meet with SPD to reconcile remaining ICP cash payment either within 30 days of the date of disenrollment or before the termination date, whichever is sooner.

(b) Involuntary disenrollment. The participant may be involuntarily disenrolled from the ICP when the participant, representative, or employee provider does not adequately meet the participant's service needs or carry out the following ICP responsibilities:

(A) Non-payment of employee’s wages, as stated in the service budget.

(B) Failure to maintain health and well-being by obtaining personal care as evidenced by:

(i) Decline in functional status due to the failure to meet the participant’s needs; or

(ii) Substantiated complaints of self-neglect or neglect or other abuse on the part of the employee provider or representative.

(C) Failure to purchase goods and services according to the service plan;

(D) Failure to comply with the legal or financial obligations as an employer;

(E) Failure to maintain a separate ICP checking account or commingling ICP cash benefit with other assets;

(F) Inability to manage the cash benefit as evidenced by two or more incidents of overdrafts of the participant's ICP checking account during the last cash benefit review period;

(G) Failure to deposit monthly service liability payment into the ICP checking account;

(H) Failure to maintain an individualized back-up plan (as part of the service plan) resulting in a negative consequence;

(I) Failure to sign or follow the ICP Participation Agreement; and

(J) Failure to select a representative within 30 days if a participant needs a representative and does not have one.

(5) INTERRUPTION OF SERVICES. When a participant is absent from the home for longer than 30 days due to illness or medical treatment, the ICP cash benefit shall be terminated. The cash benefit may resume upon return to the home, providing ICP eligibility criteria is met.

(6) SELECTION OF EMPLOYEE PROVIDERS.

(a) The participant or representative carries full responsibility for locating, screening, interviewing, hiring, training, paying, and terminating employee providers. The participant or representative

must comply with Immigration and Customs Enforcement laws and policies.

(b) The participant or representative must assure the employee provider's ability to perform or assist with ADL, self-management, and twenty-four hour availability needs.

(c) Employee providers must complete a criminal history check pursuant to OAR chapter 407, division 007. If a record of a potentially disqualifying crime is revealed, the participant or representative may employ the provider at the participant's or representative's discretion.

(d) A representative may not be an employee provider regardless of relationship to the participant.

(e) Participant's relatives may be employed as employee providers.

(7) CASH BENEFIT.

(a) The cash benefit is determined based on the CA/PS assessment of need, the service plan, the level of assistance standards in OAR 411-030-0070, and natural supports.

(b) The cash benefit is calculated by adding the ADL task hours, the self-management task hours, and the twenty-four hour availability hours that the participant is eligible for as determined in the CA/PS assessment, at the rates according to the SPD rate schedule.

(c) The following services, which are approved by the case manager and paid for by SPD, are excluded from ICP cash benefit:

(A) Community health supports;

(B) Contracted non-medical waiver service transportation;

(C) Home delivered meals; and

(D) Emergency response systems.

(d) The cash benefit shall include the employer’s portion of required FICA, FUTA, and SUTA.

(e) The cash benefit shall be directly deposited into the participant's ICP designated checking account.

(8) SERVICE BUDGET.

(a) The service budget must identify the cash benefit, the discretionary and contingency funds if applicable, the reimbursement to an employee provider, and all other expenditures. The service budget must be initially approved by SPD/AAA staff.

(b) The participant may amend the service budget as long as the amendments relate to meeting the service needs and are within ICP program guidelines.

(c) A budget review to assure financial accountability and review service budget amendments must be completed at least every six months.

(9) CONTINGENCY FUND.

(a) The participant may establish a contingency fund in the service budget to purchase identified items that are not otherwise covered by Medicaid or food stamps that substitute for personal assistance and allow for greater independence.

(b) The contingency fund must be approved by the case manager, identified in the service budget, and related to service plan needs.

(c) Contingency funds may be carried over into the next month's budget until the item is purchased.

(10) DISCRETIONARY FUND.

(a) The participant may establish a monthly discretionary fund in the service budget to purchase items that directly relate to the health, safety, and independence of the participant and are not otherwise

covered under waivered services or delineated in the monthly service budget.

(b) The maximum amount of discretionary funds may be up to 10 percent of the participant's cash benefit not including employee taxes.

(c) The discretionary fund must be approved by the case manager, identified in the service budget, and related to service plan needs.

(d) Discretionary funds must be used by the end of the month.

(11) ISSUING BENEFITS.

(a) The service plan and service budget must be prior approved by the case manager before the first ICP cash benefit is paid.

(b) A cash benefit is considered issued and received by the participant when the direct deposit is made to the participant's ICP bank account or a benefit check is received by the participant.

(c) The cash benefit is exempt from resource calculations for other DHS programs only while in the ICP bank account and not commingled with other personal funds.

(d) The cash benefit is not subject to assignment, transfer, garnishment, or levy as long as it can be identified as a program benefit and is separate from other money in the participant's possession.

(12) CASE MANAGER RESPONSIBILITIES.

(a) The case manager is responsible to review and authorize service plans and service budgets that meet the ICP program criteria.

(b) If a participant is disenrolled, the case manager must review eligibility for other Medicaid long term care and community-based service options and offer other alternatives if the participant is eligible.

(c) At least every six months, SPD/AAA staff must complete a service budget review to assure financial accountability and review service budget amendments.

(13) HEARING RIGHTS. ICP participants have contested case hearing rights as described in OAR chapter 461, division 025.

Stat. Auth.: ORS 410.090
Stats. Implemented: ORS 410.070